ABSTRACT

For group therapy for aphasia to be maximally effective, group members must be engaged in the clinical interaction. Engagement is a process through which people establish, maintain, and terminate collaborative exchanges. To investigate the interactive resources employed for managing and monitoring engagement in group therapy interactions, two videotaped conversation therapy groups for aphasia were analyzed via conversation analysis. Examples of clinician behaviors that engaged group members included gaze, body orientation, gesture, and mirrored acts. In addition, gaze, gesture, body position, and shared laughter provided evidence of engagement of group members. The study of these subtle interactive elements within clinical discourse provides information about the mechanisms that promote successful clinical interactions.

KEYWORDS: Aphasia, therapy, engagement, interaction, group

Learning Outcomes: As a result of this activity, the reader will be able to describe strategies for promoting and monitoring conversational engagement in group therapy for group members with aphasia.
Bernstein-Ellis and Elman describe techniques for managing conversation groups for aphasia and for encouraging participation of group members. For example, group members are encouraged to take the conversational floor by initiating turns at talk and by providing feedback to the initiations of their peers. Their recommendations suggest that for group therapy to be maximally successful, group members must move beyond being bystanders and become fully “engaged” in the communicative interaction.

DEFINING ENGAGEMENT
Engagement is a process through which people establish, maintain, and terminate collaborative interactions, and it implies a degree of affective engrossment in the process. Engagement is projected in many ways through spoken utterances, joint focus on a task, or nonverbal behaviors such as gaze or gesture. Because speech-language pathologists exert considerable influence on how clinical interactions are enacted, their behaviors are likely to affect the engagement of participants in group therapy. To ensure participation in group activities, therapists need to elicit engagement and also monitor various conversational conventions that reflect each group member’s level and manner of engagement.

Although it may appear to be a simple, obvious concept, engagement is, in fact, a complex and multilayered collaborative achievement. What are the precise mechanisms for engaging individuals with pervasive communication disorders in successful exchanges? Even though engagement in clinical interactions appears to be a critical element of successful intervention, little specific guidance is available in the speech-language pathology literature. Therefore, research was initiated to explore the topic of engagement in group therapy for aphasia.

METHOD
Participants
The data for this study were selected from a large pool of videotapes of clinical interactions. Each session in the pool of videotaped sessions had been rated on a global scale from “excellent therapy” to “very poor therapy” by two experienced speech-language pathologists. Two group therapy sessions were chosen from this pool to represent interesting examples of engagement. One of the purposefully chosen sessions had been rated as very poor (group 1); the other had been rated as very good therapy (group 2).

Both groups were conducted in a university speech and language clinic by student clinicians fulfilling clinical practicum requirements. Both groups were described as “conversation group therapy” for aphasia and each group lasted ~50 minutes. Both groups occurred near midsemester, and each group included three people with aphasia (Tables 1 and 2) and three student clinicians. Each student clinician was assigned to one of the clients with aphasia as that person’s primary therapist. The groups were videotaped with a stationary camera that captured all participants; both groups were accustomed to being videotaped as part of routine clinical procedures.

Data Analysis
Conversation analysis of the two group therapy sessions for aphasia was undertaken. Conversation analysis has been used to describe talk-in-interaction among ordinary individuals and to reveal communication practices in populations with communication disorders. Because of its focus on the sequential placement of conversational turns in larger segments of interaction, it is useful for identifying and describing the complexities and patterns of seemingly mundane social actions.

In keeping with conversation analysis procedures, the sessions were orthographically transcribed using specific notation conventions (Table 3). Transcripts and videotapes were reviewed repeatedly to identify interactional turn sequences consistent with a broad definition of engagement as a behavior that established, maintained, or terminated an exchange. For each identified instance, the specific strategies or interactional resources employed to achieve engagement were
described and analyzed. Finally, the good and the poor sessions were compared and contrasted to further define characteristics of engagement as well as the reverse process: “disengagement”.

RESULTS
The analysis of the two therapy sessions revealed several interactive behaviors associated with the negotiation of engagement. Although a variety of behaviors contributed to interactive engagement, gaze, body orientation, gesture, and joint laughter are highlighted in the following discussion via selected examples drawn from the data analysis. These particular behaviors are described because of their sensitivity to engagement as an interactional achievement.

Signals of Engagement via Gaze and Body Orientation: Group 1
The first example selected to explicate engagement in group therapy for aphasia comes from the group rated as “poor” therapy (group 1). The arrangement of group members was roughly U-shaped with one clinician at the head of the U. The conversational topic was childhood illnesses. As the excerpt opens, the clinician at the head of the table (Clinician 1) is concluding a turn at talk and has leaned back in her chair to write on a tablet. Clinician 2 also sits back in her chair looking down at a tablet. Kay and Cindy, two clients with aphasia, are sitting back in their chairs. Kay is looking at Clinician 1; Cindy is looking at Clinician 2. Clinician 3 turns sideways to face Jack, a man with aphasia. Jack has a midlevel gaze that is not clearly directed at anyone; as he begins to talk in line 7, he looks down, then shifts his gaze toward Clinician 3.

EXAMPLE 1
1. Group Members: ((gazing at Clinician 1))
2. Clinician 1: Yeah, I had that too.
3. ((leans back and looks at her tablet as she talks))
4. ((begins writing on her tablet as she stops talking))
5. Clinician 2: ((shifts gaze away from Clinician 1))
6. ((gazes at her own tablet and begins to write))
7. Jack: (. ) What happened when I was 15 . . . 19 . . . = ((looking down, speaking in a quiet voice))
8. ((shifts gaze to Clinician 3 as he talks))
9. Kay: ((shifts gaze to Jack))
10. Jack: ((looks at Clinician 3)) and all the sudden=
11. Clinician 3: =mhm= ((oriented sideways to face Jack))
12. Jack: = just bam xxxx((taps table))
13. Clinician 2: ((Shifts gaze to Jack))
15. Clinician 3: Everywhere? ((still shifted sideways gazing at Jack))

Table 1 Description of Participants with Aphasia in Group 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Etiology</th>
<th>Diagnosis</th>
<th>Severity</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jack</td>
<td>Male</td>
<td>66</td>
<td>CVA</td>
<td>Wernicke’s aphasia</td>
<td>Mild-Moderate</td>
<td></td>
</tr>
<tr>
<td>Kay</td>
<td>Female</td>
<td>55</td>
<td>CVA</td>
<td>Broca’s aphasia</td>
<td>Moderate Severe</td>
<td>Right Hemiplegia</td>
</tr>
<tr>
<td>Cindy</td>
<td>Female</td>
<td>52</td>
<td>CVA</td>
<td>Broca’s aphasia</td>
<td>Moderate</td>
<td>Right Hemiparesis</td>
</tr>
</tbody>
</table>

CVA, cerebrovascular accident.

Table 2 Description of Participants with Aphasia in Group 2

<table>
<thead>
<tr>
<th>Name</th>
<th>Gender</th>
<th>Age</th>
<th>Etiology</th>
<th>Diagnosis</th>
<th>Severity</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joe</td>
<td>Male</td>
<td>62</td>
<td>CVA</td>
<td>Anomic aphasia</td>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Patty</td>
<td>Female</td>
<td>66</td>
<td>CVA</td>
<td>Anomic aphasia</td>
<td>Mild</td>
<td></td>
</tr>
<tr>
<td>Cindy</td>
<td>Female</td>
<td>52</td>
<td>CVA</td>
<td>Broca’s aphasia</td>
<td>Moderate</td>
<td>Right Hemiparesis</td>
</tr>
</tbody>
</table>

CVA, cerebrovascular accident.
 Clinician 1 finishes a turn at talk about a childhood illness in line 1. However, she does not follow the conversational convention of “selecting the next speaker.” Speaker selection is often communicated via gaze and body orientation along with aspects of talk. For example, speakers shift gaze toward the person that is the next designated speaker at an appropriate “turn relevance juncture” within talk. By allowing speakers to designate who talks next and skillfully employing these “gaze windows” to engage listeners, the conversation can move along without confusion and overlap among speakers. When the speaker holding the floor does not select who talks next in conversation, other speakers have the right to self-select. Clinician 1 does not select a next speaker. Rather, she turns to her paperwork and disengages from the group. Because Clinician 1 is at the head of the table in the “power chair,” her disengagement is potentially quite influential. Clinician 2 follows suit and disengages from group interaction to look at her papers. Kay and Cindy look toward their clinicians (Clinicians 1 and 2), possibly awaiting a signal for group conversation to commence. Thus the participants are “engaged” in a variety of different attentional tracts when Jack begins to speak.

As Jack self-selects to take up the turn at talk in line 7, everyone except his own student clinician is oriented away from Jack by gazing elsewhere. It is therefore not surprising that he turns toward and fixes his gaze on his own student clinician (Clinician 3), and he directs his utterance to her. He talks in a relatively quiet voice and never shifts his gaze back to other group members. In response, Clinician 3 gazes directly at him and maintains a sideways body position toward him. When she orients to Jack and excludes the rest of the group, she has effectively taken up Jack’s signal that he is talking to her, and they collaboratively engage with one another. From this point on, Jack and Clinician 3 are actively involved in an exchange while the other group members do not participate in the conversation. In effect, Jack and Clinician 3 have a dyadic conversation. The key behaviors that establish and maintain the engagement of Jack and Clinician 3, and disengagement from others, are body orientation and eye gaze.

Interestingly, once Jack and Clinician 3 begin to converse, then others begin to turn and gaze toward them. However, the dyadic pattern of engagement has been established and the rest of the group is left without a clear way to signal their active involvement in the ensuing conversation. Instead, the rest of the group serves as audience members or bystanders who are “disengaged” as conversational participants. Their peripheral role in this interaction is reflected in the total absence of back-channel behaviors (e.g., “mhm,” “Oh”) from Clinicians 1 and 2, Kay, or Cindy. None of the clinicians or clients attempts to reorient the conversation to the group, and the nonparticipating members appear bored and passive.

By continuing to keep her body alignment and eye gaze focused exclusively on Jack, Clinician 3 effectively disengages the rest of the group from their two-party conversation. To avoid this, she might have opened her body orientation and gaze to signal to Jack that the rest of the group should be included in the interaction. That is, through gaze and body orientation, Clinician 3 could have addressed
her comments to others and helped them enter the exchange. As noted in the introduction, group therapy differs from individual therapy because more participants are providing opportunities for multiparty conversation. However, in this extract, Jack and Clinician 3 are engaging in an individual session with onlookers. This example demonstrates how the group members, particularly the clinicians, have collaborated to construct an interaction in which two people talk to each other and the rest of the group are not actively engaged in the conversation.

Signals of Engagement via Gaze and Body Orientation: Group 2

The second example of engagement in group therapy comes from the group rated as “good” therapy. In this session the group members sit in a circle with no obvious “lead position.” As the example begins, the group has been discussing pets, and Clinician 1 has just described her pet, a “noisy” and colorful macaw. Group members gaze in her direction; then when she concludes her utterance, Clinician 1 glances at Patty, who takes up the turn at talk.

EXAMPLE 2

1. Clinician 1: So he’s really [noisy. ([gaze in direction of Patty])
2. Patty: [You can .]((pointing at Clinician 1))
3. Group: ((all members gaze at Patty; Joe & Clinician 1 lean toward her))
4. Patty: find parrots that do that do that too.
5. Just like .)you talkin about.
6. ((pointing at Clinician 1; group shifts gaze to Clinician 1))
7. Group: ((gaze of group members focused toward Clinician 1))
8. Clinician 1: I think it must just depend on,you know
9. Group: ((gaze of group members shifts toward Clinician 2))
10. Clinician 2: [Yeah::, nice thing about a bird
11. you can put the sheet over em=
12. ((group laughter in background))
13. Group: ((gaze shifts from Clinician 2 to Patty as Patty agrees))
14. Patty: =Yeah you right! You right!
15. Cindy: [Yeah
16. Clinician 1: ((shifts body & gaze to the right and points to Joe))
17. Joe: ((shifts gaze and body toward Clinician 1))
18. Group: ((shifts gaze toward Clinician 1 and Joe))
19. Clinician 1: So you […]((pointing to Joe))
20. Joe: [He has a a big uh cage uh? ((holds hands wide apart))
21. Clinician 1: Yeah, he has a big cage outside((holds hands wide apart))
22. Group: ((group members gaze at Joe))

Throughout this interaction there is movement. Eye gaze shifts from speaker to speaker and participants orient their bodies inward toward the group interaction allowing for shifting of turns to new speakers. Clinician 1 effectively selects Patty as the next speaker at an appropriate juncture in talk via gaze and body orientation (line 1). Patty speaks to the group by gazing outward and opening her body position up toward the group. In line 8, Clinician 1 begins to respond to Patty; however, Clinician 2 interrupts for a humorous comment, shifting the focus of the group away from Clinician 1. In other words, Clinician 2 stifled the development of a “dyad” within the group by joining the talk of Patty and Clinician 1. Group members appear to recognize these signals of engagement, and they involve themselves in the group by looking at the speakers, laughing at appropriate junctures (line 12), and offering back-channel agreements (lines 14, 15).

From lines 1 through 15, Clinician 1, Clinician 2, Patty, and Cindy have made comments. Although Joe has been engaged via eye gaze and body orientation, he has not yet entered the talk. At this point, Clinician 1 turns her body and shifts her gaze toward Joe, points to him, and begins a question. In effect, Clinician 1 is attempting to draw Joe deeper into the group involvement—to heighten his level of engagement. Her orientation toward him creates a signal and “slot” for him to enter the conversation. Because Joe tends to be slow at
initiating talk, Clinician 1’s visible selection of Joe as a speaking partner allows him to enter the conversation successfully. By visually and physically orienting toward Joe, this clinician has moved him from the periphery to the center of the interaction.

**Signals of Engagement via Gesture**

The preceding examples demonstrated the use of body position and gaze to manage engagement in conversation. Other signals of engagement were also apparent in Group 2. For example, gesture functioned as an effective strategy for drawing participants into the conversation. By pointing to Joe in lines 16 and 19, Clinician 1 not only selects him as the intended next speaker, she also signals her active involvement with him in the unfolding interaction. In the following excerpt, the discussion of pets continues, and gesture creates a joint focus of engagement for Clinician 1 and Joe.

**EXAMPLE 3**

20. Joe: He has a big uh cage uh? (hands wide apart)
21. Clinician 1: He has a big cage outside (hands wide apart)
22. but when he comes in I put him in a little cage. (moves hands closer)
23. He likes that cage... it’s a big one. (hands wide apart)
24. Joe: It’s a big one, yeah yeah.

By “mirroring” Joe’s wording and gestures (holding hands wide apart), Clinician 1 projects animated attention to and interest in Joe’s question. Here, the mirroring of gestures, body movements, and wording demonstrates synchronicity in conversation. The joint focus exhibited in this passage is indicative of a high level of engagement and mutual orientation to the topic.

**Shared Laughter as Evidence of Engagement**

The affiliation and joint engagement of Clinician 1 and Joe in Example 3 quickly shifts back to include the group as the interaction continues.

**EXAMPLE 4**

28. Joe: I’ve got a cat and uh uh fishes at the moment but [I mean
29. Cindy: [where?
30. Joe: ((shrugs, hand out)) I usually usually find it on a doorstep.
31. Clinician 1: You find them?
32. Joe: Yes, I take it in ((laughing))
33. Clinician 3: That’s how my mom got all those dogs. ((laughing))
34. Group: ((laughing))
35. Joe: ((laughing and nodding)) yes yes
36. Patty: What place she have that many dogs?

In this segment we find another example of positive engagement: shared laughter. Whereas gaze, gesture, and body orientation are resources used by clinicians (and clients) to engage one another in the conversation, shared laughter displays the results of shared involvement. Several researchers have pointed out that when one person laughs in a group and others join in and laugh along, it signals a form of affiliation and joint focus.\(^{45}\) Shared laughter demonstrates that participants are involved in the appreciation of humor.\(^{46}\) The laughter is precipitated by Joe’s comment in line 32 indicating that he picks up stray animals, and the follow-up comment from Clinician 3 refers back to a prior discussion about her mother’s proclivity for collecting strays. Group members laugh together at Joe and the clinician’s mom sharing this trait. This shared laughter reflects a high level of group engagement and solidarity.

In contrast to example 1, extracts 2, 3, and 4 reveal a marked difference in levels of group member engagement in conversation. Whereas the clinicians in group 1 demonstrated limited use of strategies to engage group members in conversation, clinicians in group 2 displayed a range of resources to promote engagement among all members as evidenced in the use of gaze, gesture, body orientation, and mirroring. In the “good” group, members took turns, asked questions, and made comments as they explored the topic of pets. In the poor group, four of the six participants sat passively.
DISCUSSION

Analysis of these group therapy sessions provides insight into discourse behaviors that promote substantive conversational engagement of people with aphasia in a group setting. Certainly, no group interaction sustains continued heightened involvement of all members. However, these examples demonstrate that various conversational conventions can be marshaled to engage others in conversation, whereas other behaviors appear to be associated with diminished conversational engagement by group members. Although engagement is a collaboratively constructed activity, clinicians are in a position to subtly manage the engagement levels of group members using strategies such as gaze, body orientation, and gesture. By using these subtle "contextualization cues," signals are created in the ongoing discourse that encourage clients with aphasia to enter the conversation. In addition to gaze, gesture, and body position, it is likely that a host of additional signals (e.g., tone of voice, facial expression, physical setting) serve to enlist the involvement of group members and display interest and heightened attention. By contrast, therapist behaviors such as disengaging from the group to read notes or to enter scores on a score sheet disrupt the process of group involvement.

Not only do the identified behaviors serve as resources to manage levels of engagement, such behaviors can also serve as conversational markers that help conversational participants monitor levels of engagement of others. In other words, instances of gaze orientation or shared laughter provide a "running" snapshot of a group member's level of engagement in the interaction. For example, the shared laughter and mutual gaze orientation of members of group 2 demonstrated that the clinicians and clients had been successful in engaging one another in the conversation. The result was an overall impression of involvement, interest, and attention among all members.

CONCLUSION

The findings of this study confirm that engagement can be observed and strategies can be employed for maximizing engagement in therapy. Although many signals such as these are taken for granted within the complex stream of clinical interaction, many of the behaviors examined in this study (e.g., body orientation, gaze) are simple yet powerful influences on clinical processes. If effective therapy does indeed depend on active engagement of clients, then clinicians need information such as this regarding communicative strategies that aid engagement. Studies of clinical discourse are potentially valuable learning tools for clinicians seeking to improve their clinical skills and for teaching students embarking on clinical training experiences. By studying subtle interactive elements within clinical discourse, we gain information about the mechanisms that promote successful speech and language therapy, and we learn methods to improve therapy interactions with those who depend on the clinical skills of speech-language pathologists.

REFERENCES


35. Wilkinson R. Sequentiality as a problem and resource for intersubjectivity in aphasic conversation:
38. Simmons-Mackie N, Damico JS. Reformulating the definition of compensatory strategies in aphasia. Aphasiology 1997;8:761–781
44. Goodwin C. Gestures as a resource for the organization of mutual orientation. Semiotica 1986;62:29–49
47. Gumperz J. Discourse Strategies. Cambridge, MA: Cambridge University Press; 1982